ACMS-VT SCENARIOS DEVELOPMENT TOOL

For use of this form, see TC 8-800; the proponent agency is TRADOC.

PART 1. Trauma Scenario - (TABLES I - II)

Critical		Scenario Flow
	Condition: (Brief description of situation)	
*	**Body Substance Isolation:** (During combat may not apply)	
*	**Scene Assessment:**	
*	**Mechanism of Injury:** (What caused the injury?)	
*	**Number of Casualties:**	
*	**Assistance?**	Yes ☐ No ☐
*	**Stabilize Spine:**	Yes ☐ No ☐
	General Impression of Casualty: (Condition casualty is encountered)	
*	**Mental Status (LOC)**	A V P U responsiveness
*	**Chief Complaint:**	
*	**Airway:** (Patent?)	Yes ☐ No ☐
*	**O_2 Therapy**	Yes ☐ No ☐ What? _____ Adjunct: Yes ☐ No ☐ What? _____
*	**Breathing:**	Rate: _____ /min Rhythm: _____ Quality: _____
*	**Bleeding:**	Yes ☐ No ☐
*	**Pulses:** (Palpable?)	Carotid: Yes ☐ No ☐ Quality: _____
		RUE: Yes ☐ No ☐ Quality: _____ LUE: Yes ☐ No ☐ Quality: _____
		RLE: Yes ☐ No ☐ Quality: _____ LLE: Yes ☐ No ☐ Quality: _____
*	**Skin:**	Color:
		Temperature:
		Condition:
*	**Signs and symptoms of shock?**	Yes ☐ No ☐
*	**Transport priority:**	
*	**Appropriate assessment**	Focused or Rapid Trauma assessment

EVALUATORS GUIDELINE: By completing the **Scenario Flow** column with the information requested in Column 2, the evaluators can create their own scenario.

Rapid Trauma Assessment		
Head		
	DCAP-BTLS?	Yes ☐ No ☐
	Crepitus?	Yes ☐ No ☐
Neck		
	DCAP-BTLS?	Yes ☐ No ☐
*	**Tracheal deviation?**	Yes ☐ No ☐
	JVD?	Yes ☐ No ☐
	C-spine step-offs? (Applies cervical collar)	Yes ☐ No ☐
Chest		
	DCAP-BTLS?	Yes ☐ No ☐
	Crepitus?	Yes ☐ No ☐
	Paradoxical motion?	Yes ☐ No ☐
*	**Breath sounds?**	Absent / present / equal / diminished: _____ lobe
Abdomen		
	DCAP-TRD?	Yes ☐ No ☐
Pelvis		
	DCAP-BTLS?	Yes ☐ No ☐
*	**Instability and crepitus?**	Yes ☐ No ☐
	Level of pain?	
	Priapism?	Yes ☐ No ☐
Extremities (1 point for each extremity)		
*	**DCAP-BTLS and assessment of motor, sensory, and circulatory function**	RUE: _____ LUE: _____ RLE: _____ LLE: _____
Posterior		
	DCAP-BTLS?	Yes ☐ No ☐
	Rectal bleeding?	Yes ☐ No ☐
*	**SAMPLE History**	S: A: M: P: L: E:
*	**Baseline Vital Signs**	P: R: BP:
*	**Level of pain?** **Morphine?**	Pain: Yes ☐ No ☐ Level: _____ Morphine: Yes ☐ No ☐

	Perform a Detailed Physical Exam (performed during evacuation)		
	Scalp and Cranium		
	DCAP-BTLS?	Yes ☐	No ☐
	Crepitus?	Yes ☐	No ☐
	Ears		
	DCAP-BTLS?	Yes ☐	No ☐
	Drainage (blood / clear fluid)?	Yes ☐	No ☐
	Face		
	DCAP-BTLS?	Yes ☐	No ☐
	Eyes		
	DCAP-BTLS?	Yes ☐	No ☐
	Discoloration?	Yes ☐	No ☐
	Unequal pupils?	Yes ☐	No ☐
	Foreign bodies?	Yes ☐	No ☐
	Blood in anterior chamber?	Yes ☐	No ☐
	Nose		
	DCAP-BTLS?	Yes ☐	No ☐
	Drainage (blood / clear fluid)?	Yes ☐	No ☐
	Mouth		
	DCAP-BTLS?	Yes ☐	No ☐
	Loose or broken teeth?	Yes ☐	No ☐
	Foreign objects?	Yes ☐	No ☐
	Swelling or laceration of the tongue?	Yes ☐	No ☐
	Unusual breath odor?	Yes ☐	No ☐
	Discoloration?	Yes ☐	No ☐
	Neck		
	DCAP-BTLS?	Yes ☐	No ☐
	JVD?	Yes ☐	No ☐
	Tracheal deviation?	Yes ☐	No ☐
*	**Crepitus?**	Yes ☐	No ☐
	Chest		
	DCAP-BTLS?	Yes ☐	No ☐
	Crepitus?	Yes ☐	No ☐
*	**Breath sounds?**	Absent / present / equal / diminished: _____ lobe	
	Flail chest?	Yes ☐	No ☐
	Abdomen		
	DCAP-BTLS?	Yes ☐	No ☐
	TRD (Tenderness, Rigidity, and Distention)	Yes ☐	No ☐
	Pelvis		
	DCAP-BTLS?	Yes ☐	No ☐
	Instability?	Yes ☐	No ☐
	Crepitus?	Yes ☐	No ☐

Extremities (1 point for each extremity)		
	DCAP-BTLS and assessment of motor, sensory, and circulatory function	RUE: _____ LUE: _____ RLE: _____ LLE: _____
Posterior		
	DCAP-BTLS?	Yes ☐ No ☐
	Rectal bleeding?	Yes ☐ No ☐
Manage Secondary Injuries		
*	**Injuries found during survey**	
Reassess Vital Signs		
	Obtain Vital Signs	P:
		R:
		BP:

PART 2. Medical Scenario - (TABLES III - IV - V)		
Critical		**Scenario Flow**
	Condition: (Brief description of situation)	
*	**Body Substance Isolation:** (During combat may not apply)	
*	**Scene Assessment:**	
	Mechanism of Injury: (What caused the injury?)	
	Number of Casualties:	
	Assistance?	Yes ☐ No ☐
	Stabilize Spine:	Yes ☐ No ☐
	General Impression of Casualty:	
	Mental Status (LOC)	A V P U responsiveness
*	**Chief Complaint:**	
*	**Airway:** (Patent?)	Yes ☐ No ☐
*	**O_2 Therapy**	Yes ☐ No ☐ What?_____
	Breathing:	Rate ____/min Rhythm: _____ Quality: _____
*	**Bleeding:**	Yes ☐ No ☐
	Control Bleeding?	Yes ☐ No ☐
*	**Pulses:** (Palpable?)	Carotid: Yes ☐ No ☐ Quality: ____
		RUE: Yes ☐ No ☐ Quality: ____ LUE: Yes ☐ No ☐ Quality: ____
		RLE: Yes ☐ No ☐ Quality: ____ LLE: Yes ☐ No ☐ Quality: ____
*	**Skin:**	Color:
		Temperature:
		Condition:
	Transport priority:	
*	**SAMPLE History**	S:
		A:
		M:
		P:
		L:
		E:
	Baseline Vital Signs:	P:
		R:
		BP:
*	**Interventions:** (Casualty treatment?)	
*	**Level of pain?**	Pain: Yes ☐ No ☐ Level: _____
	Morphine?	Morphine: Yes ☐ No ☐
	Transport:	
	Detailed Physical Examination:	Verbalizes: Yes ☐ No ☐
	Ongoing Assessment:	Verbalizes: Yes ☐ No ☐

EVALUATORS GUIDELINE: By completing the **Scenario Flow** column with the information requested in Column 2, the evaluators can create their own scenario.